Petitions for Change of Primary Treating Physician
(Labor Code § 4603 and Title 8, Cal. Code of Regulations, § 9786)

How to File a Petition

Please remember that you are ***required*** to use the Division's petition form (DWC Form 280). Be certain to attach a Proof of Service by Mail Declaration indicating service of the petition, all exhibits, and ***Part B*** of the DWC Form 280, on the Employee, or the Employee's attorney, ***and*** the current primary treating physician.

An Original Signature is **Required**: The petition must contain the petitioner's **ORIGINAL** signature. A stamped signature or a typed name is not acceptable.

A petition that is not on the required DWC form, or where the response form was not served on the Employee or the Employee's attorney and the primary treating physician will be dismissed. An unverified response to a petition will not be considered.

Please use correct citations: Remember that Sections 9785 and 9786 are contained in Title 8 of the California Code of Regulations, they are not in the Labor Code. They may be cited as "8 CCR 9785". Prior Administrative Director's decisions are not citable precedent.

Mail the original petition or response to: Administrative Director Division of Workers' Compensation, P. O. Box 420603, San Francisco, CA 94142. **Do Not** file the petition or response with your local WCAB office.

Note: As of 2/8/99, the DWC is no longer located at 45 Fremont St., Suite 3160, San Francisco and the forwarding order has expired.

Please do not file copies of every medical report in your possession concerning the subject case. However, you should file a copy of every ***relevant*** medical report - any report that is pertinent to the issues raised in your petition.

If you are alleging that the treating physician did not comply with the reporting requirements, you must provide evidence that you notified the physician of the complete and current reporting requirements ***prior to*** the physician's failure to properly report (See 8 CCR 9786(b)). Be specific in your arguments, by providing dates, and the subsections of Section 9785 which were allegedly violated (e.g. ***Vague***: "Dr. X has not complied with Section 9785". ***Specific:*** "Dr. X has not complied with Section 9785(f)(8) since she has not submitted a progress report since October 1, 1999"). Remember to include a copy of the text of the regulations you sent to the physician.

Grounds for Filing a Petition (See 8 CCR 9786)

(1) The primary treating physician has not complied with the reporting requirements contained in § 9785.

(2) The primary treating physician is not within a reasonable geographic area.

(3) The current treatment plan is not consistent with the treatment plan submitted pursuant to Section 9785.

(4) The primary treating physician has a ***potential*** and ***significant*** conflict of interest in continuing as the employee's physician (e.g. physician father treating an immediate family member).

Timeframes for Issuance of a Decision (See 8 CCR 9786(d))

The Administrative Director must, within 45 days of receipt of the petition, either: (1) issue a decision GRANTING, DENYING, or DISMISSIMG the petition; (2) refer the matter to the WCAB for hearing and determination by a workers' compensation judge; (3] issue a notice extending for 30 days the time period for issuance of a decision or [4] develop the record by extending the time for decision and ordering the filing of additional documentary evidence.

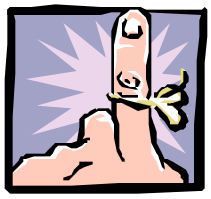
Appeals from the Decision of the Administrative Director (See 8 CCR 9787)

An appeal must be filed within 30 days of service of the decision Granting or Denying the decision. The appeal should be filed directly with the appropriate district office of the Workers' Compensation Appeals Board. Do **not** file the appeal with the Administrative Director or the WCAB Reconsideration Unit in San Francisco.

You may only appeal from a decision Granting or Denying a petition. You may not appeal a decision ***Dismissing*** a petition.

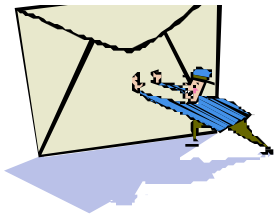
Reference WCAB Rules of Practice and Procedure, Section 10950 for a discussion of the filing procedures for an appeal.

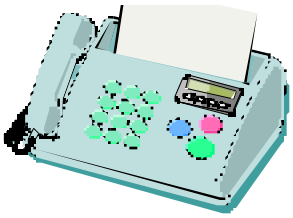
Helpful Facts to Remember



The primary treating physician is only required to send one copy of his/her report to the claims administrator, and is not obligated to send additional copies to the defense attorney or the employer. However, instead of receiving the reports directly, the claims administrator may designate any person or entity to be the recipient. (See 8 CCR 9785(c))

The primary treating physician may submit reports by regular mail, FAX, or by any other method ***agreed to the claims administrator.***





Progress reports submitted at 45 day intervals may be submitted on the "Primary Treating Physician's Progress Report (Form PR-2). The physician may submit a report in narrative form provided: (1) it is entitled "Primary Treating Physician's Progress report" in **bold-faced type**, (2) it indicates clearly the reason the report is being submitted, and (3), it contains the same information using the same subject headings in the same order as Form PR-2 (See 8 CCR 9785(f)(8)).

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
ADMINISTRATIVE DIRECTOR
Post Office Box 420603
San Francisco, CA 94142

PETITION FOR CHANGE OF PRIMARY TREATING PHYSICIAN

(LABOR CODE § 4603 & TITLE 8, CALIFORNIA CODE OF REGULATIONS, § 9786)

(Print or Type Names and Addresses)

WCAB Case Nos. (If any):_____

EMPLOYEE: _____

EMPLOYEE'S ADDRESS:_____

EMPLOYEE'S ATTORNEY: _____

EMPLOYEE'S ATTORNEY'S ADDRESS_____

EMPLOYER:_____

EMPLOYER'S ADDRESS:_____

CLAIMS ADMINISTRATOR:_____

CLAIMS ADMINISTRATOR'S ADDRESS:_____

CLAIMS ADMINISTRATOR'S CLAIM NUMBER(S):_____

NAME OF PRIMARY TREATING PHYSICIAN _____

PRIMARY TREATING PHYSICIAN'S ADDRESS:_____

PHYSICIAN PANEL: List below the **NAMES, ADDRESSES and MEDICAL SPECIALTIES** (e.g.-orthopedics, cardiology, etc.) of a panel of FIVE (5) physicians (to include one chiropractor if the employee is being treated by a chiropractor) available to provide treatment of the employee's injury in the event this petition is granted.

1._____

2._____

3._____

4._____

5._____

Petitioner states that the following constitutes good cause for issuance of an *Order Granting Petition For Change Of Primary Treating Physician:* (Additional sheets may be attached if necessary)

NOTE: Attach to this Petition any supportive evidence (medical reports, declarations, etc.) that establishes good cause for the Petition to be granted. (See Title 8, California Code of Regulations, Section 9786)

VERIFICATION

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

EXECUTED AT _____, CALIFORNIA ON _____
(City) (Date)

BY: _____ // _____
Original Signature of Petitioner's Representative Preparing the Petition // Name of Petitioner's Representative Preparing the Petition (Print or type)

_____
(Address of Petitioner)

_____

YOU MUST ATTACH A PROOF OF SERVICE BY MAIL DECLARATION INDICATING THAT: (1) PART A (PETITION FOR CHANGE OF PRIMARY TREATING PHYSICIAN) *AND* PART B (RESPONSE TO PETITION FOR CHANGE OF PRIMARY TREATING PHYSICIAN) OF THIS FORM AND (2) ALL SUPPORTIVE EVIDENCE WERE MAILED TO THE EMPLOYEE OR THE EMPLOYEE'S ATTORNEY, AND THE PRIMARY TREATING PHYSICIAN.

Notice to Employee/Employee's Attorney and Primary Treating Physician:

Pursuant to Title 8, California Code of Regulations, Section 9786(d), you may file with the Administrative Director a RESPONSE to this petition within 20 days from the date the petition was served on you. Your Response must be submitted using the *Response to Petition for Change of Treating Physician* form which is contained in Part B on Pages 3 and 4 of this form. You may attach additional sheets as needed to the Response form.

STATE OF CALIFORNIA
DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION
ADMINISTRATIVE DIRECTOR
Post Office Box 420603
San Francisco, CA 94142

RESPONSE TO PETITION FOR CHANGE OF PRIMARY TREATING PHYSICIAN

(LABOR CODE § 4603 & TITLE 8, CALIFORNIA CODE OF REGULATIONS, § 9786(d))

(*Print or type names and addresses)*

WCAB Case Nos. (If any):_____

EMPLOYEE: _____

EMPLOYEE'S ATTORNEY_____

EMPLOYER:_____

CLAIMS ADMINISTRATOR:_____

CLAIMS ADMINISTRATOR'S CLAIM NUMBER:_____

NAME OF PRIMARY TREATING PHYSICIAN _____

The petition filed by or on behalf of the Claims Administrator does not establish good cause for the issuance of an *Order Granting Petition For Change Of Primary Treating Physician based on the following:* (additional sheets may be attached if necessary)

IMPORTANT: Attach to this Response any supportive documentary evidence (medical reports, affidavit and declaration, etc.) which establishes that there is not good cause for the Administrative Director to grant the Petition for Change of Primary Treating Physician. (See *Title 8, California Code of Regulations, § 9786)*

VERIFICATION

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

EXECUTED AT _____, CALIFORNIA ON _____
(City) (Date)

BY: _____//_____
Original Signature of Person Preparing the Response // Name of Person Preparing the Response (Print or type)

Address:

_____

***NOTICE TO EMPLOYEE/EMPLOYEE'S ATTORNEY*: THE PROOF OF SERVICE BY MAIL DECLARATION BELOW MUST BE COMPLETED INDICATING A COPY OF THIS RESPONSE HAS BEEN MAILED TO THE CLAIMS ADMINISTRATOR OR ITS ATTORNEY, AND THE PRIMARY TREATING PHYSICIAN.**

***NOTICE TO PRIMARY TREATING PHYSICIAN*: THE PROOF OF SERVICE BY MAIL DECLARATION BELOW MUST BE COMPLETED INDICATING A COPY OF THIS RESPONSE HAS BEEN MAILED TO THE CLAIMS ADMINISTRATOR OR ITS ATTORNEY, AND THE EMPLOYEE OR THE EMPLOYEE'S ATTORNEY.**

PROOF OF SERVICE BY MAIL

On _____I served a copy of this Response to Petition for Change of Treating Physician on
(date)
_____ at _____and
(Claims Administrator or its Attorney) *(address)*
_____ at _____by
(Primary Treating Physician or Employee/ Employee's Attorney) *(address)*

placing a true copy enclosed in a sealed envelope, addressed as indicated above and with postage fully prepaid, in the U.S. Mail at_____, California. I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

_____//_____
Original Signature of Declarant // Name of Declarant (Print or Type)

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send tow copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER NAME AND ADDRESS | **PLEASE DO NOT USE THIS COLUMN**

2. **EMPLOYER NAME** | **Case No.**

3. Address No. and Street City Zip | **Industry**

4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.) | **County**

5. **PATIENT NAME** (first name, middle initial, last name) | 6. Sex ☐ Male ☐ Female | 7. Date of Birth Mo. Day Yr. | **Age**

8. Address: No. and Street City Zip | 9. Telephone number ( ) | **Hazard**

10. Occupation (Specific job title) | 11. Social Security Number - - | **Disease**

12. Injured at: No. and Street City County | **Hospitalization**

13. Date and hour of injury or onset of illness Mo. Day Yr. Hour _____ a.m. _____ p.m. | 14. Date last worked Mo. Day Yr. | **Occupation**

15. Date and hour of first examination or treatment Mo. Day Yr. Hour _____ a.m. _____ p.m. | 16. Have you (or your office) previously treated patient? ☐ Yes ☐ No | **Return Date/Code**

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination

B. X-ray and laboratory results (State if non or pending.)

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ☐ Yes ☐ No
ICD-9 Code ___ ___ ___ - ___ ___

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☐ Yes ☐ No If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes ☐ No If "yes", please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location Date admitted Mo. Day Yr. Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? ☐ Yes ☐ No
If "no", date when patient can return to: Regular work ____/____/____
Modified work ____/____/____ Specify restrictions _____

Doctor's Signature _____ CA License Number _____

Doctor Name and Degree (please type) _____ IRS Number _____

Address _____ Telephone Number (_____)_____

FORM 5021 (Rev. 4)
1992

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

State of California Additional pages attached ❑
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the box(es) which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or IMC Form 81556.

☐ Periodic Report (required 45 days after last report) ☐ Change in treatment plan ☐ Discharged
☐ Change in work status ☐ Need for referral or consultation ☐ Info. requested by:_____
☐ Change in patient's condition ☐ Need for surgery or hospitalization ☐ Other:

Patient:
Last _____ First _____M.I._____Sex _____
Address_____ City_____ State _____ Zip_____
Date of Injury_____ Date of Birth_____
Occupation_____SS # _____-_____-_____ Phone (___)_____

Claims Administrator:
Name_____ Claim Number _____
Address_____City_____ State_____ Zip_____
Phone (___) ___ _____ FAX (_____) _____

Employer name: Employer Phone ( )

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective complaints:

Objective findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

Diagnoses:
1. _____ ICD-9 _____
2. _____ ICD-9 _____
3. _____ ICD-9 _____

Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. **Identify each physician and non-physician provider.** Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture). Use of CPT codes is encouraged. Have there been any **changes** in treatment plan? If so, why?

Work Status: This patient has been instructed to:

☐ Remain off-work until_____.

☐ Return to *modified* work on_____ with the following limitations or restrictions
(List all specific restrictions re: standing, sitting, bending, use of hands, etc.):

☐ Return to full duty on _____with no limitations or restrictions.

Primary Treating Physician: (original signature, do not stamp) Date of exam: _____

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code § 139.3.

Signature:_____ Cal. Lic. # _____
Executed at:_____ Date: _____
Name: _____ Specialty: _____
Address: _____ Phone: _____
Next report due no later than _____

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)

This form is designed to be used by the primary treating physician to report the initial evaluation of permanent disability to the claims administrator. It should be completed if the patient has residual effects from the injury or may require future medical care. In such cases, it should be completed once the patient's condition becomes permanent and stationary or has reached maximum medical improvement.

This form should not be used by a Qualified Medical Evaluator (QME) or Agreed Medical Evaluator (AME) to report a medical-legal evaluation.

Patient:

Last Name_____ Middle Initial ____ First Name _____Sex ____ Date of Birth _____
Address _____City _____State _____ Zip _____
Occupation _____ Social Security Number _____ Phone No. _____

Claims Administrator/Insurer:

Name _____ Phone Number _____
Address _____ City _____ State _____ Zip _____

Employer:

Name _____ Phone Number _____
Address _____ City _____ State _____ Zip _____

You must address each of the issues below. Use of the form below is optional. You may substitute or append a narrative report if you require additional space to adequately report on these issues.

Date of Injury_____ Last date _____ Date of current _____Permanent & _____
Date worked Date examination Date Stationary date Date

Description of how injury/illness occurred (e.g. Hand caught in punch press; fell from height onto back; exposed 25 years ago to asbestos):

Patient's Complaints:

PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)

Relevant Medical History:

Objective Findings:

Physical Examination: (Describe all relevant findings; include any specific measurements indicating atrophy, range of motion, strength, etc.; include bilateral measurements - injured/uninjured - for upper and lower extremity injuries.)

Diagnostic tests results (X-ray/Imaging/Laboratory/etc.)

Diagnoses (List each diagnosis; ICD-9 code must be included) ICD-9

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

	Yes	No	Cannot determine
Did work cause or contribute to the injury or illness?	☐	☐	☐
Apportionment:			
Are there pre-existing impairments/disabilities that contribute to permanent disability? If Yes, append narrative to describe cause and extent of pre-existing disability; describe any documentation of pre-existing disability.	☐	☐	☐
Can this patient now return to his/her usual occupation?	☐	☐	☐
If not, can the patient perform another line of work?	☐	☐	☐

Subjective Findings: Provide your professional assessment of the subjective factors of disability, based on your evaluation of the patient's complaints, your examination, and other findings. List specific symptoms (e.g. pain right wrist) and their frequency, severity, and/or precipitating activity using the following definitions:

Severity: Minimal pain (Min) - an annoyance, causes no handicap in performance. Slight pain (Slt) - tolerable, causes some handicap in performance of the activity precipitating pain. Moderate pain (Mod) - tolerable, causes marked handicap in the performance of the activity precipitating pain. Severe pain (Sev) - precludes performance of the activity precipitating pain.
Frequency: Occasional (Occ) - occurs roughly one fourth of the time. Intermittent (Int) - occurs roughly one half of the time. Frequent (Fre) - occurs roughly three fourths of the time. Constant (Con) - occurs roughly 90 to 100% of time.
Precipitating activity: Precipitating activity gives a sense of how often a pain is felt and thus is often provided in lieu of frequency, e.g. slight pain in back on heavy lifting, or slight-to-moderate pain in knee when standing or walking more than six hours per day. Can be used in conjunction with frequency if pain is less than constant while engaging in the precipitating activity. For example, intermittent slight pain on bending would be felt approximately 50% of time while actually engaged in bending.

Symptom	**Frequency** (Mark X at any spot)	**Severity** (Mark X at any spot.)	**Precipitating Activity**
_____	|----|----|----|----|----|----| Occ Int Fre Con	|----|----|----|----|----|----| Min Slt Mod Sev	_____
_____	|----|----|----|----|----|----| Occ Int Fre Con	|----|----|----|----|----|----| Min Slt Mod Sev	_____
_____	|----|----|----|----|----|----| Occ Int Fre Con	|----|----|----|----|----|----| Min Slt Mod Sev	_____
_____	|----|----|----|----|----|----| Occ Int Fre Con	|----|----|----|----|----|----| Min Slt Mod Sev	_____

Pre-Injury Capacity Are there any activities at home or at work that the patient cannot do as well now as could be done prior to this injury or illness?

Yes ☐ No ☐ Cannot determine ☐

If yes, please describe pre-injury capacity and current capacity (e.g. used to regularly lift 30 lb. child, now can only lift 10 lbs.; could sit for 2 hours, now can only sit for 15 mins.)

1.
2.
3.
4.

Preclusions/Work Restrictions

	Yes	No	Cannot determine
Are there any activities the patient cannot do?	☐	☐	☐

If yes, please describe all preclusions or restrictions related to work activities (e.g. no lifting more than 10 lbs. above shoulders; must use splint; keyboard only 45 mins. per hour; must have sit/stand workstation; no repeated bending). Include restrictions which may not be relevant to current job but may affect future efforts to find work on the open labor market (e.g. include lifting restriction even if current job requires no lifting; include limits on repetitive hand movements even if current job requires none).

1.
2.
3.
4.
5.
6.

Future Medical Treatment: Describe any medical treatment related to this injury that you believe the patient may require in the future. Include medications, surgery, physical medicine services, durable equipment, etc.

Comments:

STATE OF CALIFORNIA
Division of Workers' Compensation
PRIMARY TREATING PHYSICIAN'S PERMANENT AND STATIONARY REPORT (PR-3)

List any other physicians who contributed information used in this report:

A. Name _____ Specialty _____

B. Name _____ Specialty _____

C. Name _____ Specialty _____

List information you reviewed in preparing this report, or relied upon for the formulation of your medical opinions:

Medical Records

Personnel Records

Written Job Description

Any other, please describe:

Primary Treating Physician (original signature, do not stamp)

I declare under penalty of perjury that this report is true and correct to the best of my knowledge, and that I have not violated Labor Code §139.3.

Signature : _____ Cal. Lic. # : _____

Executed at : _____ Date: _____

(County and State)

Name (Printed) : _____ Specialty: _____

Address : _____ City: _____ State: _____ Zip : _____

Telephone: _____

9784 - Duties of the Employer

In addition to the duty of the employer to give notice pursuant to Sections 9782 or 9880, upon being notified of the name and address of the employee-selected physician or facility, the employer, after treatment has commenced, shall promptly authorize such physician or facility to provide all medical treatment reasonably required to cure or relieve the employee from the effects of the industrial injury, furnish the name and address of the person to whom billing for treatment should be sent, and provide such other information as is required by this Article.

The employer shall also arrange for the delivery to the selected physician or facility of all medical information relating to the claim, all X-rays and the results of all laboratory studies done in relation to the injured employee's treatment.

If the employee-selected physician or facility fails to provide adequate medical reports pursuant to Section 9785, the employer shall promptly notify said physician or facility of the requirements of Section 9785.

§9785 - Reporting Duties of the Primary Treating Physician

(a) For the purposes of this section, the following definitions apply:

(1) The "primary treating physician" is the physician who is primarily responsible for managing the care of an injured employee, and who has examined the employee at least once for the purpose of rendering or prescribing treatment and has monitored the effect of the treatment thereafter. The primary treating physician is the physician selected by the employer or the employee pursuant to Article 2 (commencing with section 4600) of Chapter 2 of Part 2 of Division 4 of the Labor Code, or under the contract or procedures applicable to a Health Care Organization certified under section 4600.5 of the Labor Code.

(2) A "secondary physician" is any physician other than the primary treating physician who examines or provides treatment to the injured employee, but is not primarily responsible for continuing management of the care of the injured employee.

(3) "Claims administrator" is a self-administered insurer providing security for the payment of compensation required by Divisions 4 and 4.5 of the Labor Code, a self-administered self-insured employer, or a third-party administrator for a self-insured employer, insurer, legally uninsured employer, or joint powers authority.

(b) There shall be no more than one primary treating physician at a time. Where the primary treating physician discharges the employee from further treatment and there is a dispute concerning the need for continuing treatment, no other primary treating physician shall be identified unless and until the dispute is resolved. If it is determined that there is no further need for continuing treatment, then the physician who discharged the employee shall remain the primary treating physician. If it is determined that there is further need for continuing treatment, a new primary treating physician may be selected.

(c) The primary treating physician, or a physician designated by the primary treating physician, shall make reports to the claims administrator as required in this section. A primary treating physician has fulfilled his or her reporting duties under this section by sending one copy of a required report to the claims administrator. However, a claims administrator may designate any person or entity to be the recipient of the required reports.

(d) The primary treating physician shall render opinions on all medical issues necessary to determine the employee's eligibility for compensation in the manner prescribed in subsections (e),

(f) and (g) of this section. The primary treating physician may transmit reports to the claims administrator by mail or FAX or by any other means satisfactory to the claims administrator, including electronic transmission.

(e)(1) Within 5 working days following initial examination, a primary treating physician shall submit a written report to the claims administrator on the form entitled “Doctor's First Report of Occupational Injury or Illness,” Form DLSR 5021. Emergency and urgent care physicians shall also submit a Form DLSR 5021 to the claims administrator following the initial visit to the treatment facility. On line 24 of the Doctor's First Report, or on the reverse side of the form, the physician shall (A) list methods, frequency, and duration of planned treatment(s), (B) specify planned consultations or referrals, surgery or hospitalization and (C) specify the type, frequency and duration of planned physical medicine services (e.g., physical therapy, manipulation, acupuncture).

(2) Each new primary treating physician shall submit a Form DLSR 5021 following the initial examination.

(3) Secondary physicians, physical therapists, and other health care providers to whom the injured employee is referred shall report to the primary treating physician in the manner required by the primary treating physician.

(4) The primary treating physician shall be responsible for obtaining all of the reports of secondary physicians and shall incorporate, or comment upon, the opinions of the other physicians in the primary treating physician's report and submit all of the reports to the claims administrator.

(f) A primary treating physician shall promptly report to the claims administrator when any one or more of the following occurs:

(1) The employee's condition undergoes a previously unexpected significant change;

(2) There is any significant change in the treatment plan reported, including, but not limited to, (A) an extension of duration or frequency of treatment, (B) a new need for hospitalization or surgery, (C) a new need for referral to or consultation by another physician, (D) a change in methods of treatment or in required physical medicine services, or (E) a need for rental or purchase of durable medical equipment or orthotic devices;

(3) The employee's condition permits return to modified or regular work;

(4) The employee's condition requires him or her to leave work, or requires changes in work restrictions or modifications;

(5) The employee is discharged;

(6) The primary treating physician concludes that the employee's permanent disability precludes, or is likely to preclude, the employee from engaging in the employee's usual occupation or the occupation in which the employee was engaged at the time of the injury, as required pursuant to Labor Code Section 4636(b);

(7) The employer reasonably requests additional appropriate information;

(8) When ongoing treatment is provided, a progress report shall be made no later than forty-five days from the last report of any type under this section even if no event described in paragraphs (1) to (7) has occurred.

Reports required under this subdivision shall be submitted on the “Primary Treating Physician's Progress Report” form (Form PR-2) contained in Section 9785.2, or in the form of a narrative report. If a narrative report is used, it must be entitled “Primary Treating Physician's Progress Report” in bold-faced type, must indicate clearly the reason the report is being submitted, and must contain the same information using the same subject headings in the same order as Form PR-2.

By mutual agreement between the physician and the claims administrator, the physician may make reports in any manner and form.

(g) When the primary treating physician determines that the employee's condition is permanent and stationary, the physician shall report any findings concerning the existence and extent of permanent impairment and limitations and any need for continuing or future medical care resulting from the injury. The information may be submitted on the “Primary Treating Physician's Permanent and Stationary Report” form (Form PR-3) contained in Section 9785.3, or using the instructions on the form entitled “Treating Physician's Determination of Medical Issues Form,” Form IMC 81556, or in such other manner as provides all the information required by Title 8, California Code of Regulations, Section 10606. Qualified Medical Evaluators and Agreed Medical Evaluators may not use Form PR-3 to report medical-legal evaluations.

(h) Any controversies concerning this section shall be resolved pursuant to Labor Code Section 4603 or 4604, whichever is appropriate.

(i) Claims administrators shall reimburse primary treating physicians for their reports submitted pursuant to this section as required by the Official Medical Fee Schedule.

§9786 - Petition for Change of Primary Treating Physician

(a) A claims administrator desiring a change of primary treating physician pursuant to Labor Code Section 4603 shall file with the Administrative Director a petition, verified under penalty of perjury, on the "Petition for Change of Primary Treating Physician" form (DWC-Form 280 (Part A)) contained in Section 9786.1.

The petition shall be accompanied by supportive documentary evidence relevant to the specific allegations raised. A proof of service by mail declaration shall be attached to the petition indicating that (1) the completed petition (Part A), (2) the supportive documentary evidence and (3) a blank copy of the "Response to Petition for Change of Primary Treating Physician", (DWC-Form 280 (Part B)), were served on the employee or, the employee's attorney, and the employee's current primary treating physician.

(b) Good cause to grant the petition shall be clearly shown by verified statement of facts, and, where appropriate, supportive documentary evidence. Good cause includes, but is not limited to any of the following:

(1) The primary treating physician has failed to comply with subdivision (e) or (f)(1-7) of Section 9785 by not timely submitting a required report or submitting a report which is inadequate due to material omissions or deficiencies;

(2) The primary treating physician has failed to comply with subdivision (f)(8) of Section 9785 by failing to submit timely or complete progress reports on two or more occasions;

(3) A clear showing that the current treatment is not consistent with the treatment plan submitted pursuant to Section 9785(e) or (f)(2);

(4) A clear showing that the primary treating physician or facility is not within a reasonable geographic area as determined by Section 9780(e).

(5) A clear showing that the primary treating physician has a possible conflict of interest, including but not limited to a familial, financial or employment relationship with the employee, which has a significant potential for interfering with the physician's ability to engage in objective and impartial medical decision making.

(c) Where good cause is based on inadequate reporting under subdivisions (b)(1) or (b)(2), the

petition must show, by documentation and verified statement, that the claims administrator notified the primary treating physician or facility in writing of the complete requirements of Section 9785 prior to the physician's failure to properly report.

Good cause shall not include a showing that current treatment is inappropriate or that there is no present need for medical treatment to cure or relieve from the effects of the injury or illness. The claims administrator's contention that current treatment is inappropriate, or that the employee is no longer in need of medical treatment to cure or relieve from the effects of the injury or illness should be directed to the Workers' Compensation Appeals Board, not the Administrative Director, in support of a Petition for Change of Primary Treating Physician.

(d) The employee, his or her attorney, or the primary treating physician may file with the Administrative Director a response to said petition, provided the response is verified under penalty of perjury and is filed and served on the claims administrator and all other parties no later than 20 days after service of the petition. The response may be filed using the “Response to Petition for Change of Primary Treating Physician” form (DWC-Form 280 (Part B)) contained in Section 9786.1. Where the petition was served by mail, the time for filing a response shall be extended pursuant to the provisions of Code of Civil Procedure Section 1013.
(e) The Administrative Director shall, within 45 days of the receipt of the petition, either:

(1) Dismiss the petition, without prejudice, for failure to meet the procedural requirements of this Section;

(2) Deny the petition pursuant to a finding that there is no good cause to require the employee to select a primary treating physician from the panel of physicians provided in the petition;

(3) Grant the petition and issue an order requiring the employee to select a physician from the panel of physicians provided in the petition, pursuant to a finding that good cause exists therefor;

(4) Refer the matter to the Workers' Compensation Appeals Board for hearing and determination by a Workers' Compensation Administrative Law Judge of such factual determinations as may be requested by the Administrative Director; or

(5) Issue a Notice of Intention to Grant the petition and an order requiring the submission of additional documents or information.

(f) The claims administrator's liability to pay for medical treatment by the primary treating physician shall continue until an order of the Administrative Director issues granting the petition.

(g) The Administrative Director may extend the time specified in Subsection (e) within which to act upon the claims administrator's petition for a period of 30 days and may order a party to submit additional documents or information.

(h) Amendments to subdivision (b) filed in 1993 shall apply only where the initial examination occurred on or after October 1, 1993. Subdivision (b) as it is existed prior to the effective date of these amendments shall remain in force where the initial examination occurred prior to October 1, 1993.